# CLIENT REGISTRATION FORM

LEGAL NAME (First/Last): _____

NICKNAME: _____ ☐ MALE ☐ FEMALE

DATE OF BIRTH: ____ / ____ / ____ PHONE NUMBER: (____) _____

PHYSICAL ADDRESS: _____ MAILING ADDRESS: (If Different) _____

☐ No Current Address/Residence

**EMERGENCY CONTACT INFORMATION *(Attach additional papers if more than one person):***

NAME (First/Last): _____ RELATIONSHIP: _____

HOME PHONE: (____) _____ WORK OR CELL PHONE: (____) _____

**ETHNICITY**

☐ HISPANIC OR LATINO
☐ NON-HISPANIC OR LATINO

**RACE**

☐ WHITE, CAUCASIAN ☐ HISPANIC
☐ AMERICAN INDIAN / ALASKAN NATIVE
☐ ASIAN ☐ BLACK / AFRICAN AMERICAN
☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
☐ OTHER _____

If you do not speak English, what is your primary language? _____

**Activities of Daily Living (ADLs)**

**Without assistance, I am unable to:**

☐ Bathe ☐ Get Dressed
☐ Eat ☐ Use the Bathroom
☐ Walk ☐ Transfer In or Out of a Bed or Chair
☐ **None – I can perform these activities**

**Instrumental Activities of Daily Living (IADLs)**

**Without assistance, I am unable to:**

☐ Prepare Meals ☐ Do Light Housework
☐ Take Medication ☐ Do Heavy Housework
☐ Manage Money ☐ Use the Telephone
☐ Shop ☐ Use Transportation Services
☐ **None – I can perform these activities**

***YOUR INCOME IS:***

**Please provide an answer on both lines:**

☐ BELOW POVERTY **OR** ☐ ABOVE POVERTY

**And is also,**

☐ BELOW 300% SSI **OR** ☐ ABOVE 300% SSI

**(The Service Provider will supply you with the current Federal Poverty Guidelines and 300% SSI amount.)**

***DO YOU:***

1. LIVE ALONE?..... ☐ Yes ☐ No
2. HAVE A DISABILITY? ..... ☐ Yes ☐ No
3. CONSIDER YOURSELF FRAIL? .... ☐ Yes ☐ No

***ARE YOU:***

1. UNABLE TO LEAVE YOUR HOME WITHOUT ASSISTANCE (Homebound)?..... ☐ Yes ☐ No
2. A VETERAN / SERVED IN ARMED FORCES? ..... ☐ Yes ☐ No
3. ON STATE MEDICAID? ..... ☐ Yes ☐ No
4. A CAREGIVER? ..... ☐ Yes ☐ No

IF YES, for whom do you provide care?

☐ Spouse ☐ Child, Age 0-18 ☐ Adult Child, 18+
☐ Parent ☐ Family Member ☐ Other _____

☐ I was provided the *Notice of Privacy Practices*

Client Signature *(Initial or Revised Registration)* _____ Date _____

Client Signature – 2nd year _____ Date _____
(I certify that my information has not changed.)

***FOR OFFICE USE ONLY***

***Services Registered For:***
☐ _____
☐ _____

***New to This Service?***
☐ Y ☐ N
☐ Y ☐ N

***Nutrition Risk Assessment Score (HD Meals):*** _____
***Site:*** _____
***Notes:*** _____

Your Name (Please Print) _____ Date _____

## DETERMINE YOUR NUTRITIONAL HEALTH

| Circle each that applies to your nutritional habits. | YES |
|---|---|
| 1. I have an illness or condition that made me change the kind and/or amount of food I eat. | 2 points |
| 2. I eat fewer than 2 meals per day. | 3 points |
| 3. I eat few fruits or vegetables, or milk products. | 2 points |
| 4. I have 3 or more drinks of beer, liquor or wine almost every day. | 2 points |
| 5. I have tooth or mouth problems that make it hard for me to eat. | 2 points |
| 6. I don't always have enough money to buy the food I need. | 4 points |
| 7. I eat alone most of the time. | 1 point |
| 8. I take 3 or more different prescribed or over-the-counter drugs a day. | 1 point |
| 9. Without wanting to, I have lost or gained 10 pounds in the last 6 months. | 2 points |
| 10. I am not always physically able to shop, cook and/or feed myself. | 2 points |
| *Total Your Nutritional Score* | |

***If your score is . . .***

**0—2** **Good! Recheck your nutritional score in 6 months.**

***If it's . . .***

**3—5** **You are at moderate nutritional risk. See what can be done to improve your eating habits and lifestyle. Refer to the attached handout for helpful tips. Recheck your nutritional score in 3 months.**

**6 or more** **You are at high nutritional risk. Bring this checklist the next time you see your doctor, dietitian or other qualified health or social service professional. Talk with them about any problems you may have. Ask for help to improve your nutritional health.**

**U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES**
**2019 FEDERAL POVERTY GUIDELINES**

| Size of family unit | Federal Poverty Guidelines *48 Contiguous States and D.C.* | |
|---|---|---|
| | Annual Income | Monthly Income |
| 1 | $ 12,490 | $1,040.83 |
| 2 | $ 16,910 | $1,409.17 |
| 3 | $ 21,330 | $1,777.50 |
| 4 | $ 25,750 | $2,145.83 |

Social Security Administration:

| | | |
|---|---|---|
| Supplemental Security Income (SSI) – 300% 1 Person Household | | $2,313 |